MONTANA
Department of Public Health & Human Services

Medicare Crossovers

Medicare Crossovers

- Claims crossover automatic from COBC-GHI
- What does cross over
  - Institutional Claims
  - Professional Claims
- What doesn't cross over (exempt)
  - Part C
  - Hospice
  - Non-assigned Medicare claims
  - Adjustments from Medicare
  - NCPDP Claims

Claims That Do Not Crossover

- Options
  - Bill electronically with appropriate Medicare qualifiers and data included in transaction
  - Bill electronically with PWK indicator and send Medicare EOB as paperwork attachment
  - Bill on paper forms

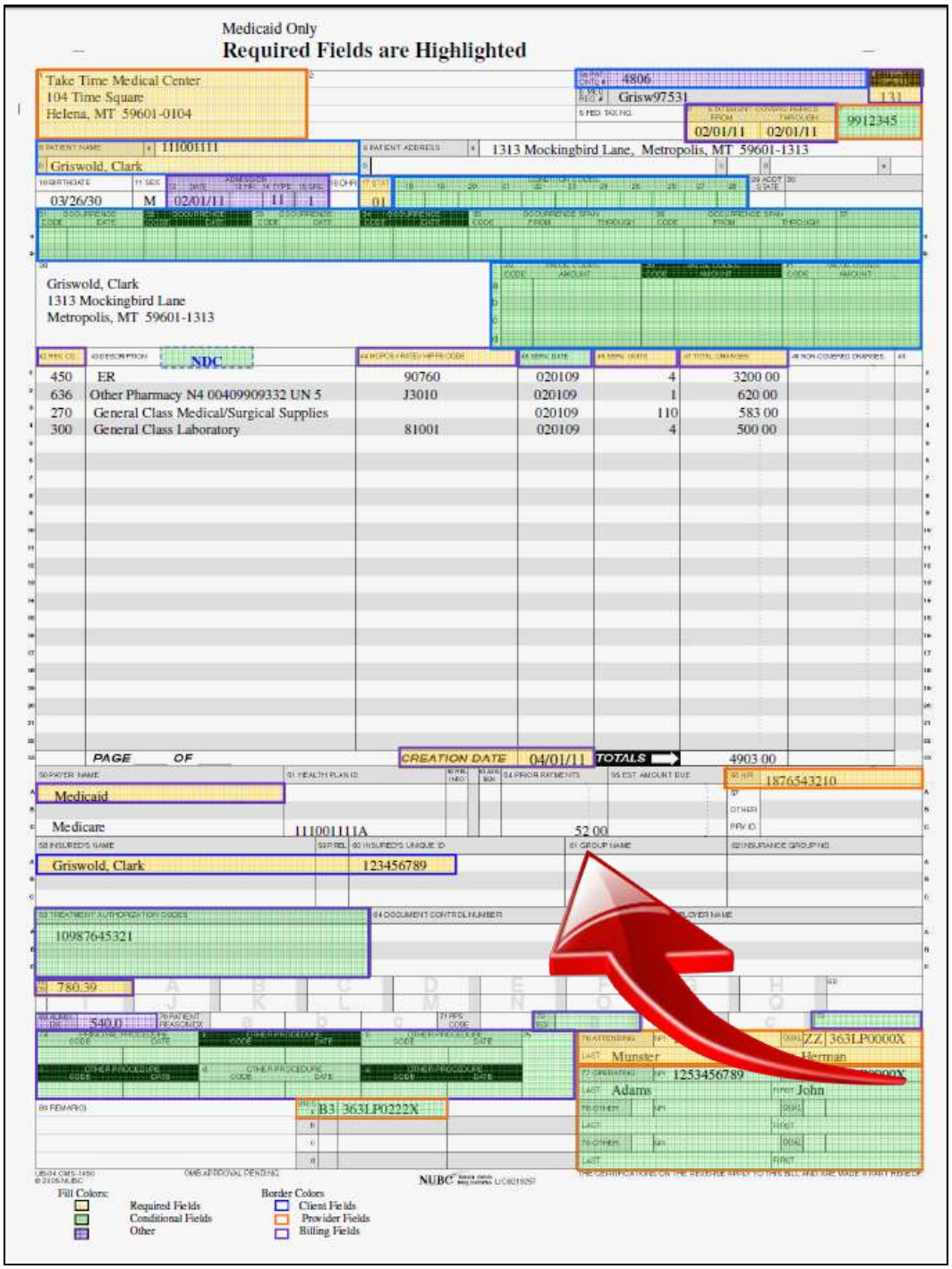
Billing Medicare Electronically

- Medicare Paid Amount:
  - Loop 2430 Segment SVD Data Element 02
    (Line Level)
- Medicare Coinsurance:
  - Loop 2430 Segment CAS Data Element 02, 05, 08, 11, 14, 17
    Claim Adj Reason Code= 2
  - Amount Loop 2430 Segment CAS Data Element 03, 06, 09, 12, 15,18
- Medicare Deductible:
  - Loop 2430 Segment CAS Data Element 02, 05, 08, 11, 14, 17
    Claim Adj Reason Code = 1
  - Amount Loop 2430 Segment CAS Data Element 03, 06, 09, 12,15,18

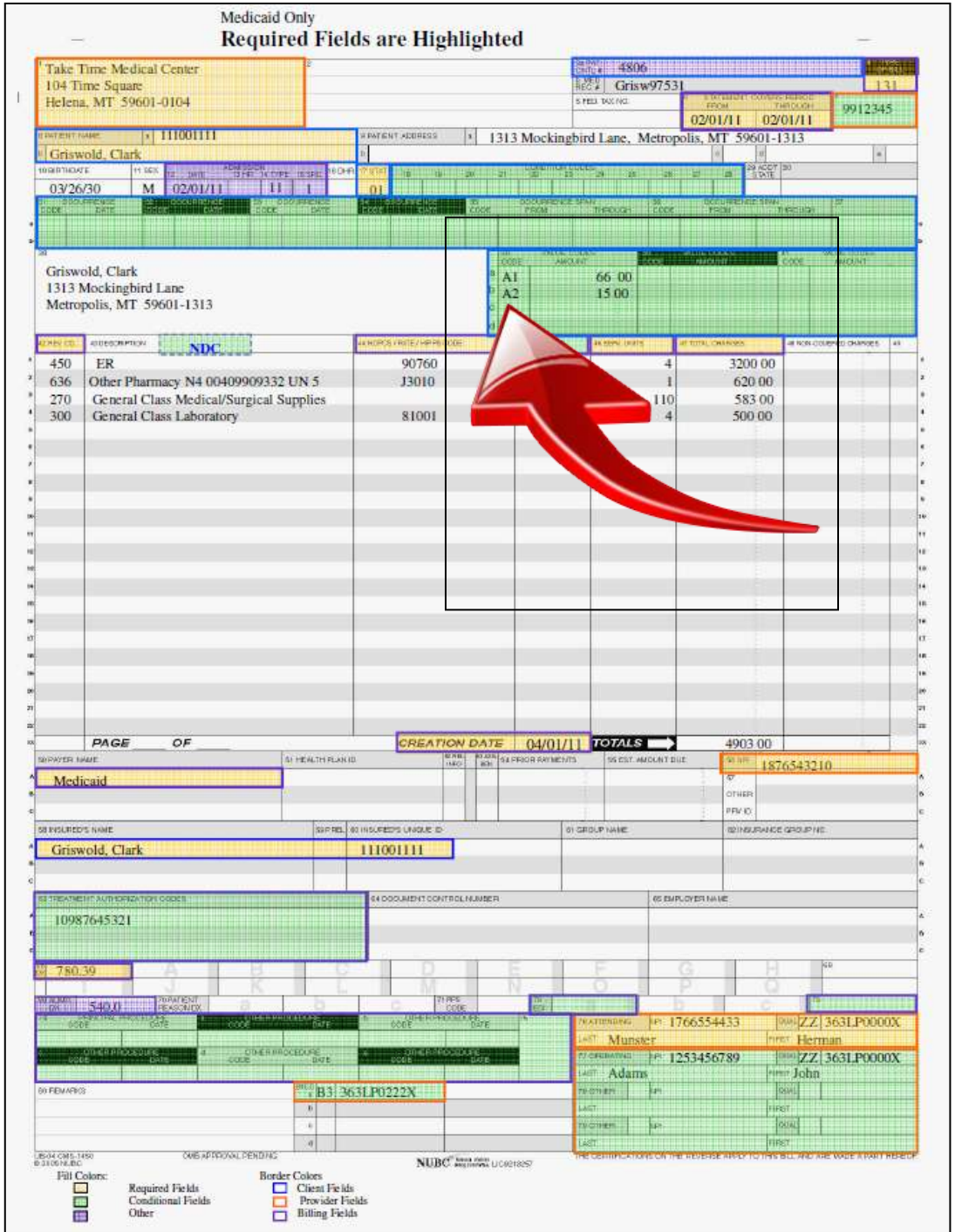
Paper Billing

- Institutional
  - Use form locators 39–41 for coinsurance and/or deductible
  - Paid amount in form locator 54
    - No EOB required for Paid Claims
  - Denials must have Medicare EOB with reason and remark codes description of reason and remark codes attached

Medicare Paid Amount



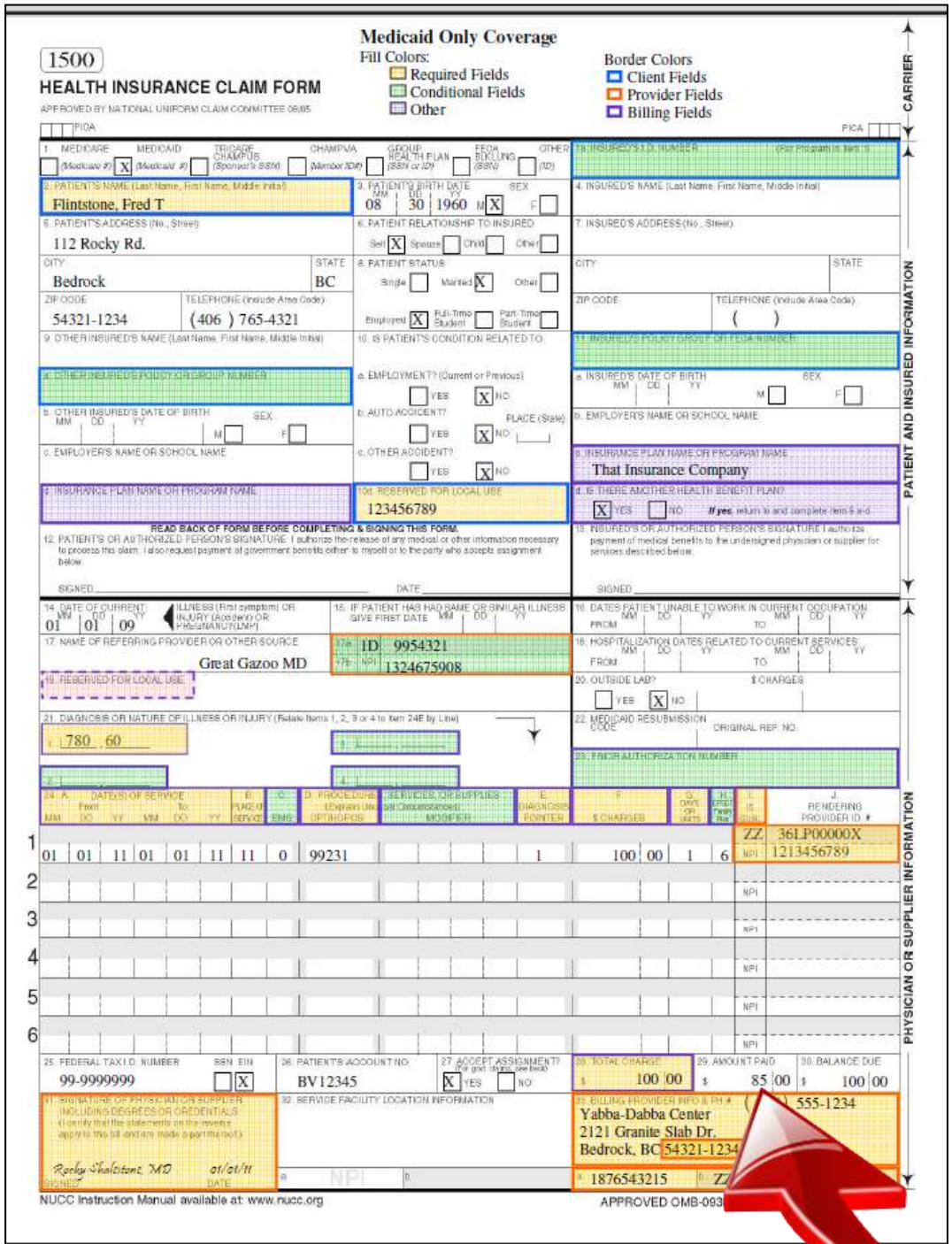
Medicare Coinsurance and Deductible



Paper Billing

- Bill on paper claim forms
  - Professional
    - Do not enter Medicare information on 1500
      - No Medicare paid amount in field 29
    - Attach a copy of the Medicare EOB for all paper claims submitted
      - Include Reason and Remark code description for all Medicare denials

TPL



Medicaid Only Coverage

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Border Colors
- Client Fields
- Provider Fields
- Billing Fields

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [ ] (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 | 30 | 1960 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME: That Insurance Company

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | 01 | 01 | 09 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a. ID 9954321

17b. NPI 1324675908

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 780.60

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	11	01	01	11	11	0	99231		1	100.00	1	6	ZZ 36LP00000X NPI 1213456789
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: BV12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 100.00

29. AMOUNT PAID: $ 85.00

30. BALANCE DUE: $ 100.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalotsme, MD 01/01/11

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. 1876543215 b. ZZ

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-093

MONTANA
Department of Public Health & Human Services

Part C
Medicare HMO Plans

- Currently processed as Medicare Part B claims
  - Copay amounts entered as deductible
  - Coinsurance entered as coinsurance
  - Deductible entered as deductible
  - Deductible + Coinsurance + Copay entered as deductible
  - Claims processing system cannot process Medicare correctly without a Medicare paid amount if a coinsurance is present
    - Medicare paid and deductible/coinsurance all considered in pricing formula

Common Issues Resulting in Denials

- Client has Medicare on file and no Medicare information is present on claim
- Medicare denied service as not medically necessary
- Medicare EOB and claim do not match
  - Check
    - Client, date of service, billed amount, and procedure code
- Medicare denial reasons are not attached

Common Issues Resulting in Denials

- Medicare denied as a duplicate
- Medicare denied for a billing error
- Medicare denied for timely filing
- Medicare denied for service not paid separately
- Medicare denied because service paid by another payer

MONTANA
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Third Party Liability

TPL Responsibilities

- Insurance verification
- Assist with problem claims
- Retro Medicare
- Carrier billing
- Provider checks/refunds
- Credit balance
- Trauma investigations

Services to You

- Pay and Chase
  - 90-Day Rule – Providers can request that Montana Health Care Programs process the claim and subsequently bill the other payer.
  - Specific circumstances result in automatic pay and chase.
    - Some prenatal and pediatric codes

Billing TPL Electronically

- TPL Information
  - Loop 2320 Segment SBR Data Element 09
- TPL Payment
  - Loop 2320 Segment AMT Data Element 02

Blanket Denial

- Include documentation that the client's other insurance never pays for a particular service.
- Requests are available on the web or from TPL. Complete and return requests to TPL. Fax to 406-442-0357.
- In return you will receive the blanket denial along with a tracking reference number to be used for billing.

MONTANA
Department of Public Health & Human Services

xerox

Request for Blanket Denial Letter

Xerox State Healthcare, LLC • State of Montana Medicaid

Effective Date Requested _____ Provider/NPI _____

Client Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____
2. _____
3. _____
4. _____
5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Fax all requests to Xerox State Healthcare, LLC, at (406) 442-0357.

Request must include an explanation of benefits (EOB) stating the services are not covered.

Updated 03/2012

How to Bill using a Blanket Denial

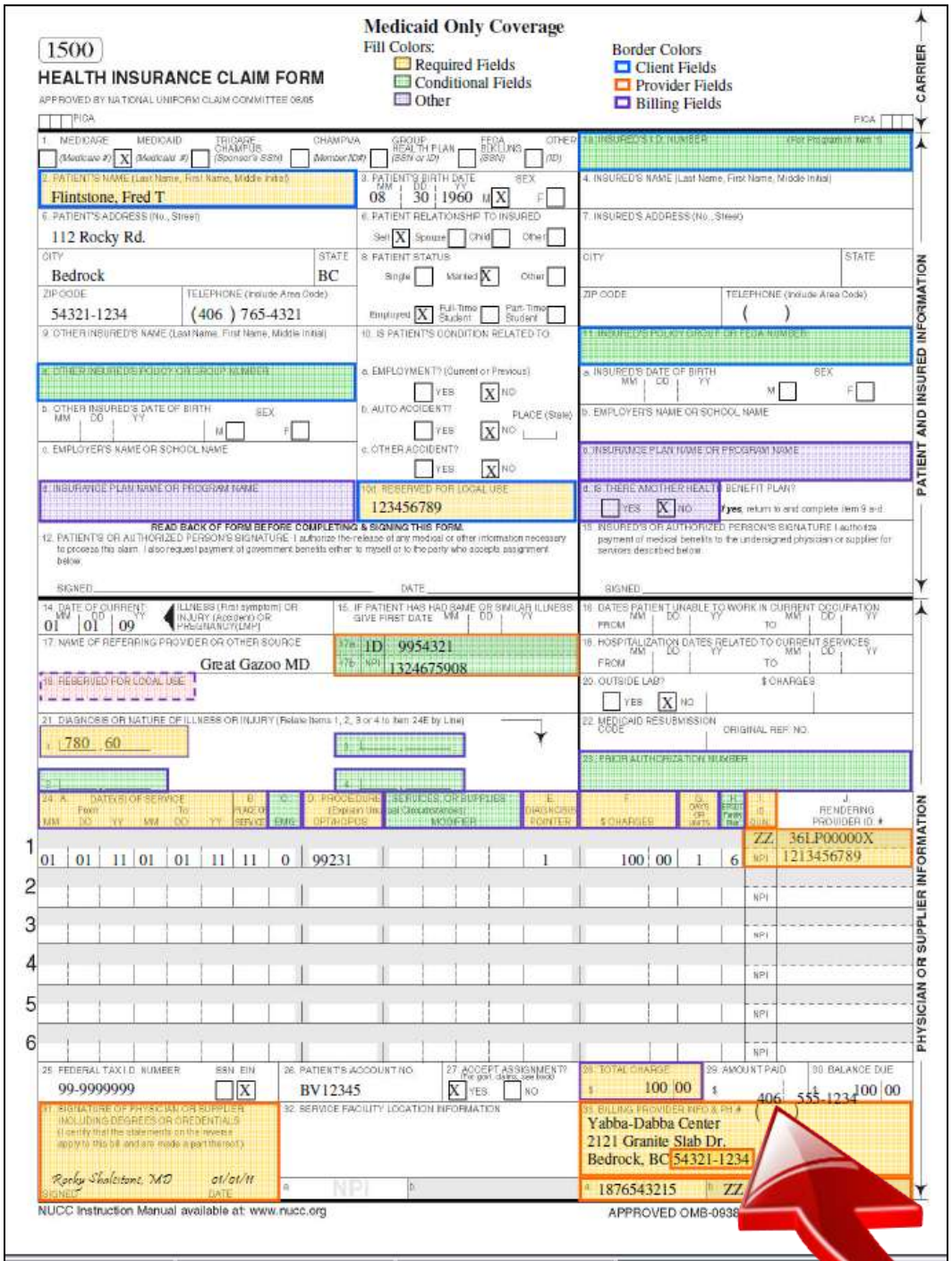
- Xerox staff work TPL edits that post for which a blanket denial has been created.
  - Electronic claims: include *pwk* indicator
  - Paper claims: send the claim only

- Blanket denials are valid for two years from date on the request. Renewals must be requested and are not automatic.

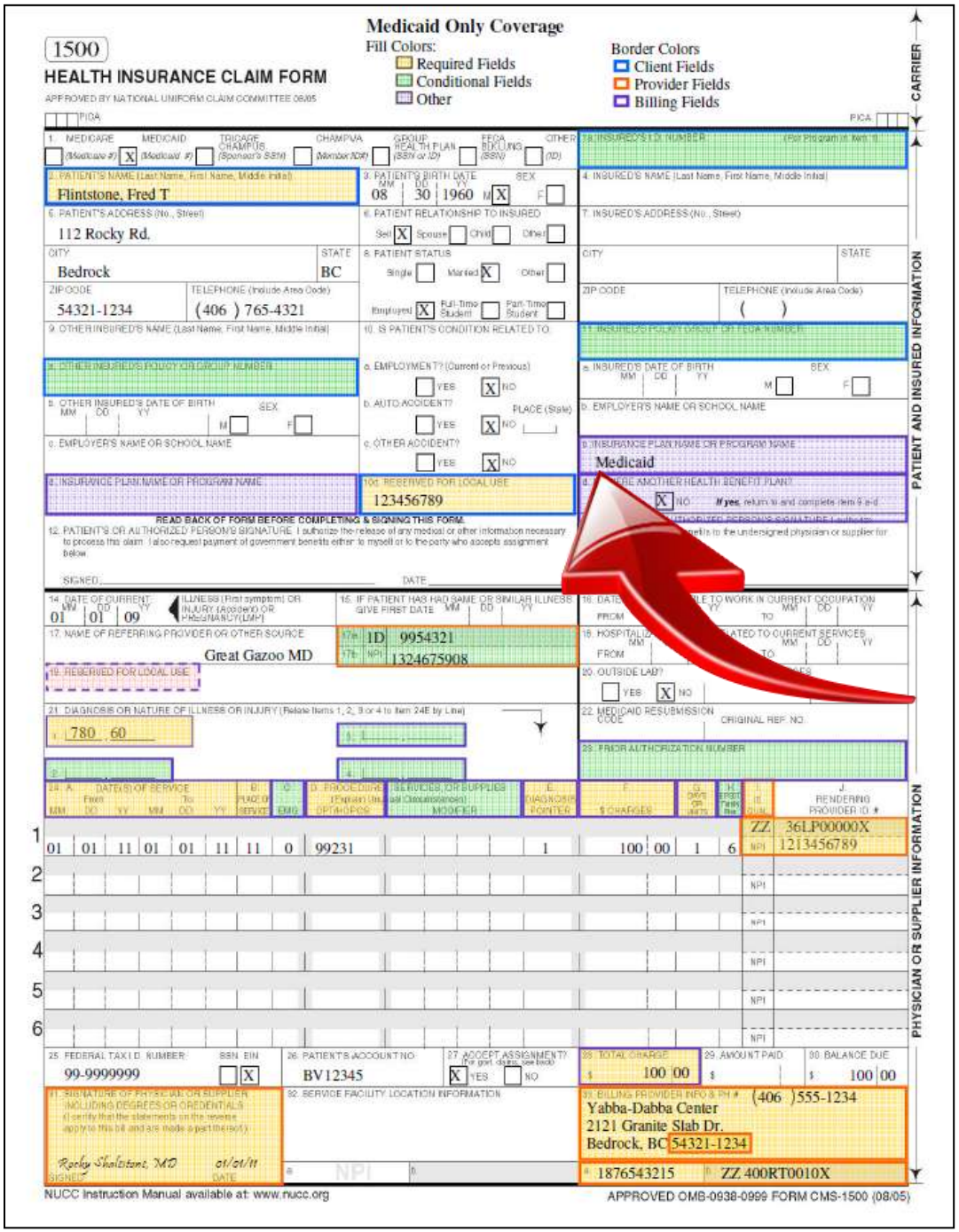
Common Problems

- No TPL amount on the claim
  - If you have information TPL has termed, please call Provider Relations at 1-800-624-3958
- Medicare information is put in as a TPL amount
- No paperwork attachments

Phone Number Read as TPL



Medicaid Entered as Other Insurance



What Should I Send to TPL?

- Problem TPL claims
- 90-day pay and chase claims
- Verification requests from TPL
- Blanket denials
- Refund checks
  - Note if it's for credit balance

MONTANA
Department of Public Health & Human Services

Contact Information

Julie Bullman – TPL Manager

Phone 406-457-9569

Email: julie.bullman@xerox.com

Danielle Brenimer – TPL Supervisor

Phone 406-457-9530

Email: danielle.brenimer@xerox.com

Questions